DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 10126 (01/03)

STATE OF WISCONSIN
WI Admin. Code HFS 102.01

MEDICAID AUTHORIZATION OF REPRESENTATIVE

This form must be completed by the person who completed the Medicaid application on behalf of an applicant. Documentation must be provided the applicant's local county/tribal social or human services department.

Did you complete a Medicaid/BadgerCare application on behalf of another person and are you that person's court appointed guardian or have durable power of attorney for finances for that person. ☐ Yes ☐ No

If you answered "Yes", stop here. You must submit, to the local county/tribal social or human services department, the legal documentation authorizing you to be that person's appointed guardian or durable power of attorney for finances.

Are you an authorized representative completing the Medicaid/BadgerCare application for another person? ☐ Yes ☐ No
If you are an Authorized Representative, then you and the applicant must complete the information below and you must sign the Rights and Responsibilities Section of the Medicaid/BadgerCare application. Also, both you and the applicant must sign this form in order for you to be an authorized representative.

Name - Authorized Representative (Last, First, MI)	Telephone Number ( )
Address (Street, City, State, Zip Code)	E-mail Address (Optional)

I authorize _____(name of representative) to represent me in my application for Medicaid/BadgerCare to be filed with the county/tribal human or social services department administering the program and in the reviews of my eligibility. I also authorize my representative to provide information and documents which may be necessary to establish my eligibility for Medicaid/BadgerCare. I will provide information to my representative that will be true and correct to the best of my knowledge. My representative and I understand that penalties for providing fraudulent information could be a fine of up to $25,000, imprisoned up to seven years and six months, or both and suspended from Wisconsin Medicaid. (NOTE: Someone must witness your signature other than your representative. Two witness signatures are required if you sign with an "X".)

SIGNATURE – Applicant	Date Signed
SIGNATURE – Witness	Date Signed
SIGNATURE - Witness	Date Signed

As an authorized representative I understand that I am representing the above named applicant for Medicaid/BadgerCare eligibility and that information provided is true and correct to the best of my knowledge.

SIGNATURE – Authorized Representative	Date Signed